

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

9570

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09542

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Centerville</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL Centerville</u> d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANEZ</u> Last <u>CARROLL</u>		4. DATE OF DEATH Month <u>August</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C 01</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 28 1944</u>
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Pontchartraine Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Salomon CARROLL</u>		14. MOTHER'S MAIDEN NAME <u>Sedella Wiggins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Salomon CARROLL, Centerville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Pneumothorax massive</u> DUE TO <u>gunshot wound left breast involving</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>killin vessels.</u> DUE TO <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>self infl.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>self inflicted gunshot wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>8-30 1960</u> Hour <u>11:30</u> a.m. <input checked="" type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>RURAL Centerville Q.A. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>C. R. Layton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>9-1-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 2-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pontchartraine Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Pontchartraine in Millington Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Barta</u>		ADDRESS <u>Barta Bep Centerville Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>SEP 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John G. Caswell</i>		AGE <i>32</i>		SEX <i>Male</i>	
DATE OF DEATH <i>Jan 10 1918</i>		PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>	
OCCUPATION <i>None</i>		RELIGION <i>None</i>		EDUCATION <i>None</i>	
CAUSE OF DEATH <i>Heart failure</i>		MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>None</i>	
SIGNATURE OF EXAMINER <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF WITNESSES <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF CORONER <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF JURY <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF JUDGE <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF CLERK <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF SHERIFF <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF DEPUTY SHERIFF <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF CONSTABLE <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF JURY <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF JUDGE <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF CLERK <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF SHERIFF <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF DEPUTY SHERIFF <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	
SIGNATURE OF CONSTABLE <i>John G. Caswell</i>		DATE <i>Jan 10 1918</i>		PLACE <i>Baltimore</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09543

9571

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>				c. LENGTH OF STAY IN 1b <u>54yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Y.</u> Last <u>Gardner</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1906</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea food</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
3. FATHER'S NAME <u>Henry Clay Gardner</u>				14. MOTHER'S MAIDEN NAME <u>Clara Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Mrs. Pearl Gardner</u> Address <u>Chester, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>8 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>Aug.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug 1</u> , 19 <u>60</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irwin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>8/14/60</u>			
PHYSICIAN'S NAME (Type) <u>Irwin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Aug 16-60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Stevensville</u>		22d. LOCATION (City, town, or county) (State) <u>Stevensville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u> ADDRESS <u>Church Hill</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>	

102748

CENTRAL OFFICE OF HEALTH

102748

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09544

Reg. Dist. No.

9572

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pondtown, Rural Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pondtown Rural Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Hynson				4. DATE OF DEATH Month August Day 20 Year 1960			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 18, 1889	9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Woodland				14. MOTHER'S MAIDEN NAME Lydia Elliott			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-18-6626		17. INFORMANT Naomi Garnett, Millington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 334x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 hours 14 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from March 11, 1960 to Aug 20 , 19 60 , that I last saw the deceased alive on Aug 20 , 19 60 , and that death occurred at 8:20 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED H.H. Hamilton Millington Md. 8/22/60 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) H.H. HAMILTON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 24, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		22d. LOCATION (City, town, or county) (State) Pondtown, Queen Anne Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Hollows				ADDRESS Millington, Md.		24a. REC'D BY REGISTRAR DATE AUG 24 1960	
				24b. REGISTRAR'S SIGNATURE Carlton S. Kump			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9573

CERTIFICATE OF DEATH

09545

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Millington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First John Middle E. Last Price				4. DATE OF DEATH Month August Day 31 Year 1960			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 20, 1888		9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Price				14. MOTHER'S MAIDEN NAME Rachel Munson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Elizabeth Wright, Millington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Dilatation DUE TO Chronic myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Grav. Arterio Sclerosis DUE TO (c) Septic PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Septic							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 2)			
20c. TIME OF INJURY Month 2 Day 19 Hour 2 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Sudlersville				20g. (County) Queen Anne		20h. (State) Md.	
21. I certify that I attended the deceased from Jan 1959 to Aug 31, 1960 that I last saw the deceased alive on Aug 30, 1960 , and that death occurred at 4 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sudlersville, Md. DATE SIGNED 9/11/60 ACTUAL SIGNATURE C. H. Metcalfe M.D. Sudlersville, Md. PHYSICIAN'S NAME (Type) C. H. Metcalfe							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 3, 1960		22c. NAME OF CEMETERY OR CREMATORY Prices Chapel Cemetery		22d. LOCATION (City, town, or county) (State) Sudlersville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows				24a. REC'D BY REGISTRAR DATE SEP 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hana	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED John</p>		<p>2. SEX Male</p>	
<p>3. AGE 31</p>		<p>4. DATE OF BIRTH September 20, 1880</p>	
<p>5. PLACE OF BIRTH Boston, Massachusetts</p>		<p>6. OCCUPATION None</p>	
<p>7. MARITAL STATUS Single</p>		<p>8. COLOR White</p>	
<p>9. RELIGION Roman Catholic</p>		<p>10. EDUCATION High School</p>	
<p>11. PRESENT ADDRESS 123 Main Street, Boston, Mass.</p>		<p>12. DATE OF DEATH October 10, 1911</p>	
<p>13. TIME OF DEATH 10:30 A.M.</p>		<p>14. PLACE OF DEATH Home</p>	
<p>15. CAUSE OF DEATH Diphtheria</p>		<p>16. MEDICAL HISTORY None</p>	
<p>17. SIGNATURE OF PHYSICIAN J. J. Sullivan</p>		<p>18. SIGNATURE OF REGISTRAR J. J. Sullivan</p>	
<p>19. SIGNATURE OF DECEASED None</p>		<p>20. SIGNATURE OF WITNESSES None</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9574
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09546

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>O. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		c. LENGTH OF STAY IN 1b <u>79yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Anna Roberta</u> Last <u>Reamy</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14, 1880</u>
9. AGE (In years lost birthday) yrs. <u>79</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Graham</u>		14. MOTHER'S MAIDEN NAME <u>Martha Gardner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT <u>Charles Reamy - Stevensville, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> (c) <u>1hr.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>See Yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>57</u> , to <u>Aug.</u> , 19 <u>60</u> that I last saw the deceased alive on <u>Aug. 15</u> , 19 <u>60</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>8/25/60</u> ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D. PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG. 28</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane</u> ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 29 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kane</u>			

00830

CERTIFICATE OF DEATH

M

1

CERTIFICATE OF DEATH

WILLIAM BOND

Name of deceased		WILLIAM BOND	
Age		78	
Sex		Male	
Race		White	
Date of death		April 15, 1945	
Place of death		Home	
Cause of death		Heart failure	
Disease or condition		Hypertension	
Occupation		Retired	
Signature of physician		[Signature]	
Signature of registrar		[Signature]	
Date of registration		April 16, 1945	
Place of registration		Baltimore, Maryland	
Signature of informant		[Signature]	
Date of information		April 15, 1945	
Place of information		Baltimore, Maryland	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9576 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 09548

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anneville Route 301</u>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u> 1558.2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>6229 Walkonding Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>BARBARA</u> First <u>SOKOLOFF</u> Middle Lost			4. DATE OF DEATH <u>August 26</u> Month Day Year 1960		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Spouse</u> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>???</u>		9. AGE (In years last birthday) <u>34</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>William Snow</u>		
14. MOTHER'S MAIDEN NAME <u>Cecily Meltzer</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>?</u>			17. INFORMANT <u>William Snow Montgomery</u> Address <u>105 Potters Rd</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mild PK Head + Chest Injuries</u> <u>816 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>External Causes</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>16 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident - Into ditch then into another car.</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>3:30</u> p. m. 19 <u>60</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 301</u>		20f. (City or town) (County) (State) <u>2 mi N. Bruceton Gap Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>C. R. Hayton</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-26-60</u>	
EXAMINER'S NAME (Type) <u>C. R. Hayton</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, (REMOVAL) (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Aug 28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Habor</u>	
22d. LOCATION (City, town, or county) (State) <u>Flushing New York</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Burt</u>		ADDRESS <u>Centerville Md</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

09549

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and ~~in any event~~ within 72 hours after death.

VS. AISME
5M 2/57

1. PLACE OF DEATH a. COUNTY QUEEN ANNES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince GEORGEVILLE Route 301		c. LENGTH OF STAY IN 1b 2239 Q. St N.W.		d. STREET ADDRESS Washington		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) MARCELLA		4. DATE OF DEATH Month August		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 12-1915		9. AGE (In years last birthday) 44 1/2 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Martin Wiseman		14. MOTHER'S MAIDEN NAME Joni Blattstein		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Samuel Margolis		18. ADDRESS New York N.Y.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. MEDICAL CERTIFICATION PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries DUE TO Head Chest, Compound DUE TO fracture SKULL Pelvis + An None							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Auto Accident Involved out into Another Car		23. TIME OF INJURY Hour 8:30 am p.m. Month, Day, Year 8-26-1960		24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 301		25. (City or town) 2 miles Queenstown, Md		26. (County) Prince Georges		27. (State) Md		28. NAME OF CEMETERY OR CREMATORY Scheerbrook		29. LOCATION (City, town, or county) Wilmington Delaware		30. DATE AUG 30 '60		31. REGISTRAR'S SIGNATURE Arthur S. Kraus	

